Access and Flow | Efficient | Custom Indicator

Indicator #3

Reduce blood product wastage (decrease in cost of wasted blood). (Kingston Health Sciences Centre)

Last Year		This Year	
14300	**7500**	**6786.66**	**NA**
Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement unit and program specific live-time dashboards to identify blood wastage trends.

Process measure

- Dashboard created and all clinical leaders/CLSs on-boarded.

Target for process measure

- Electronic dashboard built and 100% of leaders and CLSs on-boarded by end of Q1.

Lessons Learned

Leaders found the dashboards a very useful tool. The dashboard allowed leaders to have live data depicting unit wastage so that they could address any issues/negative trends.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Complete focused one-on-one education for nursing staff in areas of high wastage.

Process measure

- # of nurses educated.

Target for process measure

- >95% of nursing staff educated by Q4.

Lessons Learned

Education was deployed in Q1 and very effective for reaching frontline staff.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Implement blood Usage mandatory e-learning training for RNs.

Process measure

- # of nurses who have completed the LMS module.

Target for process measure

- >95% of staff completed eLearning by Q4.

Lessons Learned

E-learning was successfully created and launched to staff in Q4. We don't have feedback or metrics at this time.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Use KHSC lived experience and best practices from Toronto General Hospital to redesign the blood box packing configuration.

Process measure

- Packaging change implemented.

Target for process measure

- Implemented in all units by Q3.

Lessons Learned

New packaging was deployed in Q4. We are currently monitoring impact/ success of the new process.

Comment

For the 2023 calendar year KHSC met the target to reduce blood wastage seeing a decrease from 180,000 (3 year average) to $$95,000 in Q3. The current performance stated is the monthly average from Q3 for on-site blood wastage.

Indicator #2

Average number of lab tests per patient, per visit. (Kingston Health Sciences Centre)

Last Year		This Year	
16	**13**	**NA**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Reduce volume of blood in collection tubes (this includes testing within Clinical Biochemistry, Hematology and Transfusion medicine).

Process measure

- 1. Red Blood Cell (RBC) transfusion rate. 2. # of tubes received with appropriate volume.

Target for process measure

- RBC Transfusion volume reduction of 4% from baseline by Q4.

Lessons Learned

Low volume tubes for Chemistry, Hematology (excluding coagulation testing) and Microbiology were successfully implemented in all locations across KHSC. There was no impact on insufficient volume/recollection rates.

Post-change data is very positive. To date we have not seen a change in the number of cancelled tests. The average daily volume of blood/patient has decreased by 10 mL. For ICU patients only, preliminary data suggests a decrease in the frequency of anemia. However, longer term monitor is required to validate this trend.

Challenge: The implementation goal was to ensure that there was no wastage of the existing stock before implementing the new low-volume tubes. Some units had a higher than anticipated volume of current stock which resulted in implementation of the new tubes being delayed in some locations.

As noted above, roll-out incurred challenges with ward communication and levels of existing stock. This was overcome through improved communication and education.

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented**

Syringe used as primary collection device for lactate testing.

Process measure

- 1. Transfusion rate in ICU patients. 2. Audit of ICU lactate results 3. Recollection rate for lactate testing.

Target for process measure

- RBC Transfusion volume reduction of 4% from baseline by Q4.

Lessons Learned

As noted above, roll-out incurred challenges with ward communication and levels of existing stock. This was overcome through improved communication and education.

Change Idea #3 ☐ **Implemented** ☑ **Not Implemented**

Stop bicarbonate, urea and creatinine testing in dialysis patients.

Process measure

- Audit of creatinine, urea, bicarbonate testing in dialysis patients.

Target for process measure

- Less than 10% of dialysis patients routinely tested for creatinine, urea and bicarbonate.

Lessons Learned

Although there was support from the clinical teams on the need to implement this change, we were unable to have the support to implement this change in Nephrocare. KHSC will launch an electronic medical record in December of 2025.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Repeat HbA1c testing not less than every 90 days.

Process measure

- # of patients with HbA1C testing <90 days.

Target for process measure

- Less than 40% of patients with repeat testing every 75 days.

Lessons Learned

Successful in education of clinical teams. However, not able to build the warning rule in lab information system (LIS).

Safety | Safe | Custom Indicator

Indicator #1

% of Code White incidents where opportunities for improvement were identified. (Kingston Health Sciences Centre)

Last Year		This Year	
CB	**CB**	**51**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Revise existing Code White Debrief form and a fields in the SAFE Reporting tool to improve the process of documenting and actioning identified opportunities for improvement.

Process measure

- Revisions completed to debrief form. Revisions completed to SAFE reporting tool. Changes communicated to all leaders.

Target for process measure

- Form revisions complete. Process changes communicated to all leaders.

Lessons Learned

New fields were added to the SAFE electronic incident reporting system that asked staff, 1) what they felt caused/contributed to the behavioural escalation and 2) what they felt would have prevented the incident or resulted in a better response. The results provided valuable insight at a Manager level as well as a corporate level and was a mechanism for staff to feel “heard.” Based on staff responses, it reinforced the importance of applying behavioural management techniques and developing risk reduction plans to prevent escalation. The challenge for us was trying to determine whether changes/improvements that the staff member suggested, were implemented at the unit level.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Using feedback/information obtained from Code White incidents, along with other data sources, identify and implement corporate and unit specific initiatives, training, and resources to better support the psychological well-being of our staff and prevent psychological injury and burnout, and

Process measure

- 1) Analysis complete. 2) Action plan developed.

Target for process measure

- Analysis and action plan complete.

Lessons Learned

In Fall 2023, we conducted focus groups to obtain staff feedback on areas for improvement specific to psychological health and safety.

A number of actions were identified and implemented to improve the psychological health and safety of our staff and prevent injury and burnout including, for example:

• Development of Mindful Moments webpage and various resources (blogs, tip sheets, etc.) for staff and leaders
• Creation of a Workplace Mental Wellness Practitioner role that has allowed us to undertake initiatives such as,
- facilitating timely emotional defusings, hot debriefs, and Critical Incident Stress debriefings internally
- collaborating with specific units experiencing high level of psychological stress/distress and working with the leader to support improvement
- Attending staff huddles to have discussions on various topics related to psych H&S (e.g. communication, teamwork, building trust, strategies on supporting patients with responsive behaviours, etc.)
- Providing 1:1 psychological support to leaders and front-line staff with referrals to resources for additional support
• More formalized protocols are now in place to guide how we manage/support staff post distressing/traumatic events
• We have revised the Code White Debrief Form and made it a requirement for leaders to facilitate these debriefs to better support staff and facilitate for robust conversation.s
• Our action plan also includes the development of a Mental Wellness Strategy which is now underway for 2024-25

Challenges/Lessons learned:
It has been difficult for front line staff to attend focus groups due to staffing pressures. Instead we created Qualtrics surveys and found other opportunities to obtain feedback.

For staff huddles: We learned that leader presence is critical along with leaders having the pre-conversation with staff as to the purpose of the Mental Wellness Practitioner attending the huddles. It is challenging that not all staff are present at the time of the huddle and are seeing ways to share the valuable information with staff unable to attend.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Identify unit and/or corporate specific training needs/improvements that would help in preventing patient violence and code whites, and assist staff in more effectively managing the risk of violence.

Process measure

- 1. Needs Assessment completed. 2. Recommendations formulated for approval (Business case developed should additional funds be necessary).

Target for process measure

- 1. Needs assessment completed in Q1. 2. Recommendations formulated before end of Q2, with business case(s) if needed.

Lessons Learned

This change idea is partially implemented. Specific areas/content that would assist staff in preventing and managing aggression has been identified and is currently being incorporated into the existing workplace violence (WV) training program for the ED and MH programs.

We are investigating an e-learning component as well for all clinical staff, not just those who receive Non-Violent Crisis Intervention training.

Change Idea #4 ☑ **Implemented** ☐ **Not Implemented**

Based on opportunities already identified from code whites, develop and roll out a formal crisis management/debriefing policy and/or toolkit for leaders to ensure clarity and consistency on the provision of crisis management support to staff as a strategy to minimize the impact of psychological harm.

Process measure

- Tools completed and leaders orientated to them.

Target for process measure

- Orientation complete.

Lessons Learned

A Leaders Toolkit for Managing Traumatic and Distressing Events was developed and rolled out to leaders with orientation to the toolkit.

In addition, leaders attended training on Conducting Code White Debrief & Emotional Defusings with an creation of an Emotional Defusing Facilitation Guide for Leaders.

Challenges/Lessons learned:

Feedback on the tools and resources was positive however, future sessions will held in-person, instead of virtually, to improve the ability of leaders to practice/role play the Code White Debriefs and Emotional Defusing they will be responsible for leading.

We have also learned that one training session is not enough and in response, have set up follow up Q&A sessions for leaders to come back and explore issues, challenges, reinforce approaches, etc.